POC #2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445277	A. BUILDING _____ B. WING _____	01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCMINN MEMORIAL NURSING HOME & REHAB CENTER	886 HWY 411 NORTH ETOWAH, TN 37331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to notify the family of a change in	F 157	Resident #1's nephew was contacted by the DON on 1/10/2012. He verbalized that he was aware of Resident #1's heel wound and had been involved during the discovery and treatment process. Q2 All current residents of the facility have the potential to be affected by this deficient practice. The DON and ADON review 100% of all Event Reports and 24-hour reports on a daily basis Monday through Friday with special attention to the notification of family and physicians. Q3 All licensed staff attended an in-service education by the DON on 2/1/12 or 2/8/12 regarding the importance of notifying a resident's physician and family for any changes in condition and documenting that notification and the residence chart. Those unable to attend the meetings will be identified and educated prior to working their next shift. In-service included making sure significant changes and notification were on the 24-hour report. Charge nurses shift to shift will use the 24-hour report and monitor that family and physicians were notified regarding significant changes in treatment or events. New hires will be in-service on family and physician notification during the orientation period.	2/16/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert B Holaher	Administrato	2/8/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 09 2012

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F 157	Continued From page 1 the resident's condition for one (#1) of twenty-six residents reviewed. The findings included: Resident #1 was readmitted to the facility on November 16, 2011, with diagnoses including Dementia with Behaviors, Acute Renal Failure and Fractured Femur. Medical record review of the Minimum Data Set (MDS) dated December 12, 2011, revealed the resident required extensive assistance for all activities of daily living, and was moderately impaired for decision making. Medical record review of Nurse's Notes dated December 25, 2011, at 6:45 p.m., revealed "...3 cm (centimeter) x 3 cm darkened area on R (right) heel...MD notified..." Further medical record review revealed no documentation of family notification. Interview on January 10, 2012, at 3:15 p.m., with the Director of Nursing (DON), in the DON office confirmed the facility failed to notify the family of a change in condition.	F 157	Q4 A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator. **SEE ATTACHMENT #1**	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this	F 164		

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F 164	Continued From page 2 does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure privacy for three residents (#23, #3, #4) of twenty-six residents reviewed. The findings included: Resident #23 was admitted to the facility on January 30, 2008, with diagnoses including Diabetes, Hydronephrosis, and End Stage Renal Disease. Observation on January 12, 2012, at 10:40 a.m., revealed a volunteer entered the resident's room without knocking to provide ice to the resident.	F 164	Resident #23 : DON spoke with the Resident on 1-13-12 regarding the occurrence with the Volunteer. DON explained the resident's right to dignity and privacy. DON and informed that steps would be taken to prevent this in the future. Resident #23 verbalized no distress. Resident #3: DON spoke with Resident on 1-10-12 and apologized for incident with the nurse during treatment on feet without closing the door. Resident verbalized he was OK with incident. Discussed the residents right to dignity and privacy. Resident #4: The POA for Resident was contacted by the ADON on 1/20/12 to discuss the breach in privacy. POA verbalized it was "OK". Discussed resident's right to dignity and privacy. Q2 All current residents have the potential to be affected by this deficient practice. Q3 Nurse #1 was reeducated and counseled on 1/10/12 by the DON regarding failure to provide privacy of wound care to feet. Nurse #1 was reeducated and counseled on 1/10/12 by the DON regarding failure to provide privacy for suctioning and administration of medications via G tube. (Continued on page 4)	2/16/12

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F 164	Continued From page 3 Interview on January 12, 2012, at 10:45 a.m., with the Director of Nursing (DON), in the DON's office, confirmed the volunteers are to knock prior to entering the resident's room. Resident #3 was admitted to the facility on October 14, 2011, with diagnoses including Dementia, Benign Prostate Hypertrophy, Muscle Weakness, and Diabetes Mellitus. Observation in the resident's room on January 10, 2012, at 11:12 a.m., revealed resident #3 sitting in the room in view of other residents and visitors. Continued observation at this time revealed Charge Nurse #1 completed a treatment to the resident and failed to close the door or pull privacy curtain. Interview with Charge Nurse #1 on January 10, 2012, at 11:15 a.m., confirmed privacy was not provided during the treatment. Resident #4 was admitted to the facility on January 19, 2006, with diagnoses including Aspiration Pneumonia, Alzheimer's Dementia, and Anoxic Brain Injury. Observation in the resident's room on January 10, 2012, at 8:03 a.m., revealed resident #4 sitting in the room in view of other residents and visitors. Continued observation at this time revealed Charge Nurse #1 retrieved a suction tube from behind the resident's bed and began suctioning the resident's mouth. Continued observation in the resident's room on January 10, 2012, at 8:26 a.m., revealed the Charge Nurse pulled the resident's feeding tube	F 164	(Continued from page 3) All nursing home staff were in-service/ reeducated on 2/1/12 or 2/8/12 regarding privacy and dignity with an emphasis on knocking on all residents' room doors before entering and importance of using privacy curtains and closing doors during personal care. Persons unable to attend and PRN staff will be contacted for make-up in-service prior to next scheduled shift. New hires will be educated during their orientation. Q4 DON, ADON, Admin. And charge nurses during walk through rounds will monitor all staff as well as nursing home volunteers to ensure that privacy and dignity are promoted by knocking on doors before entering and using privacy curtains, and closing doors during personal treatments. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/ QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 164	Continued From page 4 (tube used to administer medications and feedings) through the top of the resident's shirt, administered medications through the tube and failed to close the door or pull the privacy curtain. Interview with the Director of Nursing (DON) on January 10, 2012, at 9:48 a.m., confirmed that the facility failed to ensure privacy during the resident's care.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assure one resident (#4) was assessed for self administration of drugs prior to the resident self administering medications of twenty-six residents reviewed. The findings included: Resident #4 was admitted to the facility on January 19, 2006, with diagnoses including Aspiration Pneumonia, Alzheimer's Dementia, and Anoxic Brain Injury. Medical record review of Physician's recapitulation orders signed December 15, 2011, revealed, " ...Albuterol...every 4 (four) hours...Ipratropium...every 4 hours...Acetylcysteine...three times	F 176	Resident #4 was assessed for signs and symptoms of a reaction to the medication in the nebulizer. The Resident exhibited no change in his status from 1/10/12 to 2/1/2012. Q2 All current residents could be affected by this deficiency. There are no residents at this time competent to self-medicate nebulizer treatments. Nurse #1 was counseled and reeducated by the DON on January 10, 2012 that allowing residents to self-medicate nebulizer treatments that have not been assessed for and deemed competent to perform this procedure is not permitted. Q3 All licensed nurses were reeducated on 2/1/12 or 2/8/12 about not allowing residents to self-medicate (even nebulizer treatments) unless they have been assessed and deemed competent to do so. Nurses not able to attend the meeting and PRN staff will be contacted for makeup prior to returning to work. New hires will be educated on this regulation during orientation. (Continued on page 6)	2/16/12

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F 176	Continued From page 5 daily...Dexamethasone...6 (six) times daily..." Observation of resident #4 in the resident's room on January 10, 2012, at 8:05 a.m., revealed Charge Nurse #1 placed medications in a nebulizer mask, placed the nebulizer mask around the resident's mouth and turned the nebulizer machine on. Continued observation at 8:24 a.m., revealed the Charge Nurse left the resident's room while the medications were being administered. Interview with the Director of Nursing (DON) in the Director's office, on January 10, 2012, at 9:48 a.m., confirmed the resident was not a candidate for self administration and had not been assessed for self administration of medications via (by way of) nebulizer.	F 176	Q4 The DON and ADON will monitor for compliance by observing medication pass randomly during rounds for a resident receiving nebulizer treatments. The pharmacy consultant will do a med pass oversight per month. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess for the use of a restraint for one resident (#11) of twenty-six residents reviewed. The findings included: Resident #11 was admitted to the facility on July	F 221	F 221 A restraint assessment form was completed on 01-10-12 which indicated the appropriateness of the lap hugger for Resident #11. The lap hugger is monitored per regulations, checking every 30 minutes and releasing for repositioning and toileting needs every 2 hours or as needed. Resident # 11 has order for lap hugger since 03-07-10. She is not able to remove lap hugger on command. The facility will re-assess for the need of the lap hugger with changes in conditions and quarterly with MDS assessment. Q2 All residents who currently have restraints in use could have the potential to be affected by this deficient practice. All records for residents who currently have restraints were audited for restraint assessment documentation. All residents with restraints will be assessed for changes of condition and quarterly for use of restraint.	2/16/12

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F 221	Continued From page 6 27, 2001, with diagnoses including Dementia, Cerebral Vascular Accident, and Insomnia. Medical record review of a physician's order dated April 7, 2010, revealed "...D/C (discontinue) self release belt in w/c (wheelchair) change to self release lap buddy..." Observation and interview with Charge Nurse #2 on January 10, 2012, at 4:28 p.m., in the B wing hallway, revealed resident #11 sitting in a wheelchair with a soft release belt (restraint) in place. Continued interview at this time revealed the resident could not self release the belt upon request. Interview with the Director of Nursing (DON) in the Director's office on January 11, 2012, at 9:02 a.m., confirmed the resident was unable to remove the self release belt and had not been assessed for the use of the restraint.	F 221	Q3 All nursing home staff were re-educated by the DON on restraint definition, use of and need for restraint assessment on 2/1/12 or 2/8/12. Staff unable to attend meeting and PRN staff will be notified for make-up prior to returning to work. New hires will be educated about restraints during orientation. Q4 Director of Nursing, Assistant Director of Nursing, NH Therapy Director and inter-disciplinary team will monitor for compliance of restraints and restraint assessments when a residents care plan is reviewed and/or updated. A summary restraint report is provided to the PI/QA committee quarterly. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote care that maintained or enhanced dignity during a medication administration pass for one resident (#4) of twenty-six residents reviewed.	F 241	Resident #4's POA was called on 1/20/2012 by ADON to discuss the breach in privacy by Nurse #1 on 1/10/2012. Dignity, respect and residents rights were discussed with POA. POA verbalized "Okay". Q2 Nurse #1 was counseled by the Director of Nursing on January 10, 2012 immediately following the surveyor's concern over failure to knock and re-knock on resident's door prior to entering. All current residents have the potential to be affected by this deficient practice. All staff working on January 10, 2012 was reminded by the Director of Nursing to knock on residents' doors prior to entering and upon reentering the room. (Continued on page8)	2/16/12

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F 241	Continued From page 7 The findings included: Resident #4 was admitted to the facility on January 19, 2006, with diagnoses including Aspiration Pneumonia, Alzheimer's Dementia, and Anoxic Brain Injury. Observation in the resident's room on January 10, 2012, at 7:49 a.m., revealed Charge Nurse #1 preparing to administer medications to resident #4. Continued observation revealed Charge Nurse #1 entered and exited the resident's room at 8:03 a.m., 8:21 a.m., 8:24 a.m., 8:26 a.m., 8:37 a.m., and 8:44 a.m. without knocking on the resident's door prior to entering. Interview with the Director of Nursing (DON) in the Director's office, on January 10, 2012, at 9:48 a.m., confirmed the facility failed to maintain or enhance dignity during medication administration for resident #4.	F 241	Q3 All staff was reeducated about dignity, respect and privacy with special emphasis on knocking on resident doors on 2/1/12 or 2/8/12 at staff meeting by the DON. PRN staff and those unable to attend the meeting will be reeducated prior to returning to work. All new hires are educated about dignity, respect and privacy during their initial orientation to the nursing home. Q4 All staff will be responsible to be compliant in this requirement. DON, ADON, Social Worker, NH Administrator will monitor during walking rounds and interviews with residents and family and will report to PI/QA committee quarterly. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		

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F 278	Continued From page 8 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for three residents (#1, #6, and #10) of twenty-six residents reviewed. The findings included: Resident #1 was readmitted to the facility on November 16, 2011, with diagnoses including Dementia with Behaviors, Acute Renal Failure and Fractured Femur. Medical record review of the MDS dated November 29, 2011, revealed the resident had been coded "...Formal assessment instrument... (Braden)...no Weight Loss... no ulcer care...Bowel Incontinence...Always incontinent..." Medical record review revealed no Braden skin	F 278	The MDS dated November 29, 2011 for Resident #1 was corrected January 13, 2012 to reflect that: the Braden assessment was not completed upon readmission; there was a 5% weight loss in 30 days; ulcer care; and the resident was continent. The MDS for Resident #6 dated November 10, 2011 was corrected January 13, 2012 to reflect the resident's incontinence. A bladder assessment was also completed on the same date. The MDS for Resident #10 dated August 25, 2011 was corrected on January 13, 2012 to reflect a fall since the last assessment. Q2 All current residents have the potential to be affected by this same deficient practice. All MDS's as they come due are being reviewed during the weekly interdisciplinary care plan meetings for accuracy. A personnel change is currently in process to replace the existing MDS coordinator who will be reassigned to another position. (Continued on page 10)	2/16/12

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F 278	Continued From page 9 assessment had been completed with the readmission on November 16, 2011. Medical record review of the Treatment Record dated November 2011, revealed "...Apply skin prep to R (right) heel daily until healed...", with the treatment initialed and signed by the nurse for November 25, 2011. Medical record review of the Resident Weight Record revealed "...11-17-11... (weight)126.8...11-23...(weight)120.2..." and the weight loss had not been coded on the MDS. Medical record review of the Nursing Home Resident Care Record dated November 2011, revealed no incontinent episodes of bowel had been documented. Interview on January 10, 2012, with Assistant Director of Nursing (ADON), in the B-Wing Nurse's Station, at 2:00 p.m., confirmed the was incontinent of bowel, had weight loss and developed a pressure sore, and confirmed the MDS assessment was inaccurate. Resident #6 was readmitted on October 25, 2011, with diagnoses including Septic Arthritis, Osteomyelitis, and Diabetes Mellitus. Medical record review of the MDS dated November 10, 2011, revealed the resident had been coded "... Urinary Continence...Always continent...Bowel Continence...Always Continent..." Medical record review of the Nursing Home Resident Care Record dated November 1, 2011	F 278	Q3 Education is scheduled for 2/15/12 (see attached course) for the new MDS coordinator. An audio CD has been ordered and will be mandatory for all the staff involved in MDS and care planning. All nursing home staff was in-service/educated regarding MDS assessments and documentation that affects MDS assessments by the DON on 2/1/12 or 2/8/12. Any staff unable to attend will be identified and contacted to make up the in-service. New hires will be educated on MDS and documentation use for MDS assessment during the orientation period. Q4 All MDS's as they come due will continue to be reviewed and monitored for accuracy by the interdisciplinary care plan team weekly and/or as needed meetings if there is a significant change in the resident. DON and/or ADON attend care plan meetings and will perform random MDS audits. DON will report to PI/QA committee quarterly. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 278	Continued From page 10 through November 30, 2011 revealed the resident was incontinent of urine daily, and had four incontinent episodes of BM (bowel movement) on November 5, 6, 9, and 10th. Interview on January 11, 2012, with Director of Nursing (DON), in the B-Wing Nurse's Station, at 9:00 a.m., confirmed the resident was incontinent of urine and bowels and the facility failed to ensure the MDS assessment was inaccurate. Resident #10 was admitted to the facility on May 18, 2011, with diagnoses including Dementia with Behaviors and Falls. Medical record review of the MDS dated August 25, 2011, revealed the resident had not experienced any falls, since the prior MDS assessment dated May 31, 2011. Medical record review of a Progress Notes Listing dated June 11, 2011, revealed the resident fell on June 11, 2011, at 8:55 a.m. Interview on January 10, 2012, with the Minimum Data Set (MDS) Coordinator, in the MDS office, at 2:15 p.m., confirmed the resident had a fall with no injury on June 11, 2011, and confirmed the MDS assessment was inaccurate.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 11 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to reviseupdate the Care Plans for five residents (#1, #3, #6, #10, and #16) of twenty-six residents reviewed. The findings included: Resident #1 was readmitted to the facility on November 16, 2011, with diagnoses including Dementia with Behaviors, Acute Renal Failure and Fractured Femur. Medical record review of a Nurse's Note dated November 25, 2011, revealed "...3 cm (centimeter) x (by) 3 cm darkened area on residents R (right) heel..." Medical record review of the Physician's Order Sheet dated November 25, 2011, revealed "...Apply skin prep to R heel daily until healed..."	F 280	**Resident #1's** care plan was revised on 1-13-12 to include the pressure area and treatment. **Resident #3's** care plan was revised on 1-13-12 to include the skin breakdown and treatment. **Resident #6's** care plan was revised on 1-13-12 to reflect the discontinuation of the nasogastric tube and feeding. **Resident #10's** care plan was revised on 1-13-12 to include treatment to left-hand following the surgery on January 10, 2012. **Resident #16** care plan was revised on 1-13-12 to include the pressure areas and treatment, recent fall on January 10, 2012, and fluid restriction. Q2 All current residents had the potential to be affected by this deficient practice. MDS coordinator's will receive copies of physician orders daily. Care plans will be updated Monday through Friday by the MDS coordinator's or charge nurses. Care plans will be updated on nights and weekends by the charge nurse receiving a physician order or taking care of the resident with a change in condition. Updates are to include physician orders and changes in condition. All care plans as they are due for review/revision will be reviewed for accuracy and updates by the interdisciplinary care plan team at each weekly meeting. (Continued on page13)	2/16/12

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F 280	Continued From page 12 Medical record review of a facility investigation report dated November 25, 2011, revealed "...injury related...deep tissue related..." Medical record review of the current Interdisciplinary Care Plan dated December 4, 2011, revealed the care plan had not been revised to reflect the resident's pressure ulcer. Interview with Assistant Director of Nursing (ADON) on January 10, 2012, at 8:45 a.m., at B-Wing Nurse's Station, confirmed the care plan had not been updated or revised to reflect the resident's pressure ulcer. Resident #3 was admitted to the facility on October 14, 2011, with diagnoses including Dementia, Benign Prostate Hypertrophy, Muscle Weakness, and Diabetes Mellitus. Medical record review of a Physician's Order Sheet dated November 16, 2011, revealed "...monitor R (right) medial heel abrasion...socks on with shoes..." Medical record review of the resident's current care plan revealed no documentation to reflect the skin breakdown. Interview with the Minimum Data Set (MDS) Coordinator on January 11, 2012, at 7:20 a.m., in the MDS office confirmed the facility failed to update the care plan to reflect the skin breakdown. Resident #6 was readmitted on October 25, 2011, with diagnoses including Septic Arthritis,	F 280	Q3 Special training is scheduled on February 15, 2012, for the new nurse who will be responsible for completing and updating MDS/care plans. An audio CD has been purchased for the other members of the interdisciplinary team and charge nurses for education and training which will be available after February 15, 2012 and will be required for all staff involved with care planning (interdisciplinary team and charge nurse). All staff was in-service/ educated about care plans, interim care plans, location of care plans, and adding problems and treatments to the care plan during the mandatory staff meeting on 2/1/12 and 2/8/12. PRN staff and staff unable to attend this meeting will be contacted for a makeup session prior to returning to work. Q4 The interdisciplinary care plan team, the DON and the ADON will monitor care plans for accuracy and revisions randomly and at weekly meetings. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 280	Continued From page 13 Osteomyelitis, and Diabetes Mellitus. Medical record review of the Medication Record dated December 25, 2011, revealed "...Glucerna at 45 ml/hr (milliliters/hour)...flush with 25 ml/hr...flush with free water...dc'd (discontuned).." The Glucerna was administered per nasogastric tube. Medical record review of the Physician's orders dated December 27, 2011, revealed "...may discard Hohn catheter (used for intravenous medications)..." Medical record review of the current Interdisciplinary Care Plan last reviewed on November 14, 2011, revealed the care plan had not been revised to reflect the discontinuation of the nasogastric tube or the Hohn catheter. Interview with Director of Nursing (DON) on January 11, 2012, at 9:00 a.m., at B-Wing Nurse's Station, confirmed the nasogastric tube/tube feeding and the Hohn catheter had been discontinued and the care plan had not been updated/revised. Resident #10 was admitted to the facility on May 18, 2011, with diagnoses including Dementia with Behaviors and Falls. Medical record review of the Physician Recapitulation orders dated January 2012, revealed "...clean left hand with wound cleanser...allevyn dressing coated...bactroban (antibiotic) ointment...to palm..." Further medical record review revealed the resident had been scheduled for hand surgery January 10, 2012.	F 280		

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F 280	Continued From page 14	F 280		

Medical record review of the current Interdisciplinary Care Plan last reviewed on October 24, 2011, revealed the care plan had not been revised to reflect the resident's treatment to left hand and the scheduled hand surgery.

Interview with Director of Nursing (DON) on January 11, 2012, at 9:00 a.m., at B-Wing Nurse's Station, confirmed the care plan had not been updated or revised to reflect the resident's treatment to the left hand and the scheduled hand surgery.

Resident #16 was readmitted to the facility on February 23, 2011, with diagnoses including Stage Four Renal Insufficiency, Falls, and Dementia.

Medical record review of the Skin Assessment form dated January 11, 2012, revealed "...left heel 1 cm (centimeter) x .5cm...right heel .2cm round black area...left buttocks .5 cm area..."

Medical record review of a facility investigation report dated January 10, 2012, revealed the resident had a fall on January 10, 2012.

Medical record review of a Physician's Recapitulation Orders dated December 2011, revealed an order for Fluid Restriction 1500 ml (milliliter) to 2000 ml every twenty-four hours.

Medical record review of the current Interdisciplinary Care Plan last reviewed on October 31, 2011, revealed the care plan had not been updated or revised to reflect the resident's pressure sore development, fall status, and fluid

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F 280	Continued From page 15 restrictions. Interview with MDS Coordinator on January 11, 2012, at 4:00 p.m., in the Care Plan Office, confirmed the care plan had not been updated or revised to reflect the resident's skin breakdown, fall status, and fluid restriction.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of manufacturer's instruction sheet and interview, the facility failed to follow physician's orders for five (#7, #1, #6, #10, #16) residents, failed to develop an interim care plan for five (#1, #5, #3, #13, #15) residents of twenty-six residents reviewed and failed to follow manufacturers recommendations for medication administration for one (#12) of twenty-six residents reviewed. The findings included: Resident #7 was readmitted to the facility on September 1, 2011, with diagnoses including Muscle Weakness, Paranoid Schizophrenia, Chronic Obstructive Pulmonary Disease, and Hypertension. Medical record review of a physician's order dated December 19, 2011, revealed, "...Make Meloxicam (pain medication) 7.5 mg (milligrams) po (by mouth) Bid (twice a day) prn (as	F 281	**Resident #7:** The resident's physician was notified on 1/10/12 by DON of the medication error and of the resident status of no known harm. The Mobic 7.5 by mouth twice a day was changed to twice a day PRN on 1/10/12. The aspirin 81 mg was immediately discontinued on January 10, 2012 when brought to our attention by the surveyor. **Resident #1**: the resident continues on calcium 600 mg and vitamin D 400 units since 1/5/12. The physician was notified on 1/27/12 by DON of the missed dose due to the length of time between the pharmacy recommendation, the physician signature, implementation of the change by facility and the status of the resident of no known harm. **Resident #6** continues to receive Detrol 2 mg since 11/17/11. The physician was notified on 1/27/12 by DON of the six extra doses of Detrol due to the delay between pharmacy recommendation, and physician approval, and implementation by the facility and the status of the resident of no known harm. **Resident #10** continues to receive Namenda 10 mg in the a.m. and p.m. since July of 2011. The physician was notified 7/27/12 by DON of the three wrong doses of Namenda given due to delay from the time of pharmacy recommendation, physician approval and implementation by the facility and of the resident status of no known harm. (Continued on page 17)	2/16/12

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F 281	Continued From page 16 needed)...D/C (discontinue) Aspirin 81 mg..." Review of the Medication Record dated January 1, 2012, through January 8, 2012, revealed Meloxicam 7.5 mg initialed as administered at 9:00 a.m. and 9:00 p.m. on January 1, 2012, through January 8, 2012. Review of the Medication Record dated January 1, 2012, through January 9, 2012, revealed Aspirin 81 mg initialed as administered at 9:00 a.m. on January 1, 2012 through January 9, 2012. Interview on January 9, 2012, at 2:20 p.m., with the Assistant Director of Nursing, at the nursing station, confirmed the Aspirin had been discontinued and was administered January 1-9, 2012 without a physician's order. Interview on January 10, 2012, at 9:10 a.m., with the Assistant Director of Nursing, in the Director of Nursing office, confirmed the Meloxicam was administered January 1-8, 2012 without a physician's order. Resident #1 was admitted to the facility on November 11, 2011, and readmitted on November16, 2011 after a five day hospital stay, with diagnoses including Dementia with Behaviors, Acute Renal Failure and Fractured Femur. Medical record review of a Pharmacist Consultation Report dated December 7, 2011, revealed "...consider initiating Calcium 600 mg (milligrams) with Vitamin D 400 Units twice daily..." Continued medical record review revealed the recommendation was reviewed by	F 281	Q2 All current residents have the potential to be affected by this deficient practice. Q3 All physician orders will be monitored daily M-F by audit nurse for accuracy on medication administration record and treatment record. All consults or recommendations including those from the pharmacist will be hand carried to and from the physician's office by the courier for their acceptance or rejection by the courier. These will be handled on the same day when possible or as soon as possible. In-service/education was held on 2/1/12 and 2/8/12 to all charge nurses by the DON concerning the timeliness of obtaining recommendations, physician orders and implementation of the orders. Staff unable to attend the meeting will be identified and educated on one to one by phone or upon return to work. New hires will receive education during orientation. Q4 The process to obtain approval or rejection by the physician will be monitored by the DON, audit nurses, charge nurses and the pharmacy consultant on at least a weekly basis. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 281	Continued From page 17 the physician December 16, 2011, and the physician signed the order. Medical record review of the Medication Record dated January 1, 2012, through January 31, 2012, revealed the facility failed to implement the physician's order until January 5, 2012, resulting in nineteen missed doses of the Calcium 600 mg with Vitamin D 400 units. Interview on January 10, 2012, at 8:30 a.m., with the Assistant Director of Nursing (ADON) at the B-Wing Nurse's Station, confirmed the facility failed to implement the physician's order resulting in nineteen missed doses of the Calcium 600 mg with Vitamin D 400 units. Further Medical record review revealed an Interim Care Plan had not been completed with goals and interventions after admission and prior to the development of a comprehensive care plan. Interview on January 10, 2012, at 8:45 a.m., at B-Wing Nurses Station with the Assistant Director of Nursing (ADON), confirmed an Interim Care Plan had not been completed with goals and interventions prior to the devopment of a comprehensive care plan. Resident #6 was readmitted on October 25, 2011, with diagnoses including Septic Arthritis, Osteomyelitis, Diabetes Mellitus, and Incontinence. Medical record review of a Pharmacist Consultation Report dated November 1, 2011, revealed "...consider reducing...Detrol (overactive bladder) 4 mg to 2 mg daily..." Continued	F 281		

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F 281	Continued From page 18	F 281		

medical record review revealed the recommendation was reviewed by the physician November 10, 2011, and the physician signed the order.

Medical record review of the Medication Record dated November 1, 2011, through November 30, 2011, revealed the facility failed to implement the physician's order until November 17, 2011, resulting in six doses of Detrol 4 mg instead of two mg.

Interview on January 11, 2012, at 9:00 a.m., with the Director of Nursing (DON), at the B-Wing Nurse's Station, confirmed the facility failed to implement the reduction in dosage until November 17, 2011.

Resident #10 was admitted to the facility on May 18, 2011, with diagnoses including Dementia with Behaviors and Falls.

Medical record review of a Pharmacist Consultation Report dated June 13, 2011, revealed "...consider increasing Namenda (Anti-Alzheimer) to 10 mg each am and 5 mg each pm for one week, then twice daily..." Continued medical record review revealed the recommendation was reviewed by the physician June 27, 2011, and the physician signed the order.

Medical record review of the Medication Record dated June 1, 2011, through June 30, 2011, revealed the facility failed to implement the physician's order for increasing the Mamenda dosage until June 30, 2011, resulting in the administration of three doses of the wrong

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F 281	Continued From page 19 milligrams of the Namenda. Interview on January 9, 2012, at 2:00 p.m., with the DON, in the DON office, confirmed the facility failed to implement the physician's order on June 27, 2011 until June 30, 2011 resulting in the administration of three doses of the wrong milligrams of the Namenda. Resident #16 was readmitted to the facility on February 23, 2011, with diagnoses including Stage Four Renal Insufficiency, Falls, and Dementia. Medical record review of a Physician's Recapitulation Orders dated December 2011, revealed an order for Fluid Restriction 1500 ml (milliliter) to 2000 ml every twenty-four hours. Medical record review of the Intake form, dated December 2011, revealed the fluid intake had not been documented for the resident. Interview on January 12, 2012, at 8:50 a.m., with the DON at the B-Wing Nurse's Station, confirmed the fluid restriction had not been implemented for the resident and the facility failed to follow the Physician's orders. Reseident #1 was admitted to the facility November 11, 2011, and readmitted to the facility November 16, 2011, after a five day hospital stay. Medical record review revealed an interim care plan had not been developed prior to the development of a comprehensive care plan.	F 281	**Resident #16** did not exhibit signs and symptoms of the harm from the failure to keep accurate intake on fluid restrictions. Physician notified 1-27-12 by DON. Q2 All residents on fluid restrictions in the facility had the potential to be affected by this deficient practice. Q3 The charge nurse and the CNA's who worked on January 12, 2012 were reeducated by the DON about the documentation of fluid restrictions that was brought to our attention by state surveyor. Q4 Audits of the medical record completed by the ADON and chart audit nurse demonstrated physician orders are being followed with correct documentation of fluid restrictions. The DON, ADON, charge nurses and chart audit nurse will monitor for compliance weekly. DON will report exceptions to the PI/QA committee. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator. **Resident #1's** comprehensive care plan was developed on December 4, 2011. **Resident #5's** interim care plan was completed on January 11, 2012 when brought to our attention by the state surveyor. **Resident #13's** comprehensive care plan was developed January 1, 2012. **Resident #3's** comprehensive care plan was developed on November 1, 2011. **Resident #15's** comprehensive care plan was developed on January 15, 2012. (Continued on page 21)	2/16/12

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F 281	Continued From page 20 Interview on January 10, 2012, at 8:45 a.m., at the B-Wing Nurse's Station with the ADON confirmed an interim care plan had not been completed . Resident #5 was admitted to the facility on January 3, 2012, with diagnoses including Depressive Disorder, Diabetes, Cerebrovascular Accident, and Urinary Retention. Review of the medical record revealed no interim care plan had been completed with goals and interventions prior to the development of a comprehensive care plan. Interview on January 11, 2012, at 3:00 p.m., at the nursing station, with the Director of Nursing, confirmed a interim care plan had not been completed with goals and interventions after admission to the facility. Resident #13 was admitted to the facility on December 16, 2011, with diagnosis including Fracture, Hypertension, Wound Infection, and Muscle weakness. Medical record review revealed no interim care plan completed with goals and interventions. Interview on January 12, 2012, at 9:55 a.m., at the B-Wing Nurses Station with the Director of Nursing, confirmed an interim care plan had not been completed prior to the comprehensive care plan being developed. Resident #3 was admitted to the facility on October 14, 2011, with diagnoses including	F 281	Q2 All new admissions to the facility have the potential to be affected by this deficient practice. A different interim care plan format was implemented on 1/11/12 and has been completed on resident #5 as well as three admissions since the survey. Q3 Charge nurses began to be educated on the new interim care plan format on 1/11/12. Education is ongoing. All clinical staff was educated on interim care plans during the all staff meeting on 2/1/12 and 2/8/12. Clinical staff unable to attend will be in-service upon return to work. Q4 DON, ADON and audit nurse will monitor M-F for interim care plans for each admission. A report of lack of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator. **SEE ATTACHMENT #2**	

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F 281	Continued From page 21 Dementia, Benign Prostate Hypertrophy, Muscle Weakness, and Diabetes Mellitus. Medical record review revealed the facility failed to complete an interim care plan with measurable objectives on upon admit October 14, 2011, and a comprehensive care plan was not developed until November 1, 2011. Interview with the Minimum Data Set (MDS) Coordinator on January 11, 2012, at 7:20 a.m., in the MDS office confirmed the facility failed to complete an interim care plan for resident #3. Resident #15 was admitted to the facility on December 28, 2011, with diagnoses including Muscle Weakness, Arthropathy, and Anemia. Medical record review revealed the facility failed to complete an interim care plan with measurable objectives after admit December 28, 2011, and prior to the development of a comprehensive care plan. Interview with the Minimum Data Set (MDS) Coordinator on January 11, 2012, at 7:20 a.m., in the MDS office confirmed the facility failed to complete an interim care plan for resident #15 prior to the development of a comprehensive care plan. Resident #12 was admitted to the facility on June 16, 2006, with diagnoses including Congestive Heart Failure, Cardiomegaly, and Diabetes Mellitus. Medical record review of the Minimum Data Set	F 281	**Resident #12** has exhibited no signs and symptoms from the lack of rinsing the mouth after Advair administration. The physician was notified on 1/27/12 by DON. Q2 All residents in the facility who received steroid inhalations have the potential to be affected by this deficient practice. Q3 All licensed nurses on duty on 1/10/12 were educated on proper administration of the Advair Diskus for Resident #12. Education has been on a one-on-one basis since January 10, 2012. Instructions to administer Advair inhalant correctly to all residents were repeated to all clinical staff during the all staff meeting on 2/1/12 and 2/8/12. Follow-up training for medication nurses for Advair inhalant administration was conducted by the licensed consultant pharmacist on 2/2/12 and 2/3/12. Q4 The DON and ADON will observe one Advair med pass per week for 8 weeks and then one per month. The DON will report to the PI/QA committee the results of the observations. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 281	Continued From page 22 dated November 26, 2011, revealed the resident had no short or long term memory impairment and was independent with decision making. Continued medical record review of the Physician's Recapitulation Orders dated November 18, 2011, revealed, "...Advair Diskus (type of inhaler)...use 1(one) puff twice daily..." Observation of Charge Nurse # 2 in the resident's room on January 10, 2012, at 4:50 p.m., revealed Charge Nurse #2 administered the Advair Diskus and failed to provide the resident with instructions to rinse the mouth after the inhaler dose was administered. Review of the manufactures instructions for Advair administration provided by the facility revealed, "...After each dose, rinse your mouth with water and spit the water out. Do not swallow..." Interview with the Director of Nursing (DON) on January 10, 2012, at 4:58 p.m., in the DON's office confirmed the facility failed to follow the manufactures recommendations for Advair administration.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide the necessay care/services for two residents (#16 and #23) receiving Dialysis Services. The findings included: Resident #16 was readmitted to the facility on February 23, 2011, with diagnoses including Stage Four Renal Insufficiency, Falls, and Dementia. Medical record review of the Physician's Orders dated January 1, 2012, through January 31, 2012, revealed "...outpatient dialysis..." Monday, Tuesday, and Wednesday. Medical record review of the resident's medical record on January 11, 2012, at 3:30 p.m., revealed no monitoring of the resident'd dialysis access site/vital signs after the resident's return from dialysis. Observation on January 11, 2012, at 3:20 p.m., in the resident's room revealed the resident lying on the bed and the resident had returned from outpatient dialysis. Interview on January 11, 2012, at 3:30 p.m., with Charge Nurse #6 at the B-Wing Nurse's Station, confirmed the resident returned from outpatient dialysis at 9:00 a.m., and the resident's dialysis catheter had not been assessed for bleeding, infection or the resident's vital signs had not been monitored.	F 309	**Resident #16** receives outpatient dialysis treatments at the Dialysis Center and has not experience any known harm. On 1/27/12 the facility began using a reporting form approved by the facility's medical director for all dialysis residents (including resident #16). The form has provision for reporting to and from dialysis the resident status. **Resident #23's** original orders to receive dialysis treatments at the dialysis center was obtained from the overflow section of the medical record which was dated March 12, 2010. The order was clarified with the physician and sent to be added back to the recapitulation sheet. On January 30, 2012 the nursing home administrator executed a formal transfer agreement between McMinn Memorial Nursing Home and Rehabilitation Center and the dialysis center. Both of these entities are and have been a part of the same single corporation since the dialysis center was opened in the 1990s. Q2 All residents receiving dialysis have the potential to be affected by this deficient practice. The orders for other residents receiving dialysis were audited by the ADON and audit nurse on 1/27/12 to ensure that orders for dialysis were present on the chart. (Continued on page 25)	2/16/12

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F 309	Continued From page 24 Resident #23 was readmitted to the facility on January 30, 2008, with diagnoses including Hydronephrosis and End Stage Renal Disease. Medical record review of the Physician's Orders dated January 1, 2012, through January 31, 2012, revealed no order for dialysis. Interview on January 12, 2012, at 8:50 a.m., with the Director of Nursing (DON) at the B-Wing Nurse's Station confirmed the resident received dialysis services on a out patient basis on Monday, Tuesday, and Wednesday and the facility did not have an order for dialysis services and the facility did not have a contract with the provider dialysis center used for the resident's dialysis. Interview on January 12, 2012, at 10:30 a.m., with the Nursing Home Administrator in the Conference Room confirmed the facility failed to have a contract with the outside entity providing Dialysis Services.	F 309	Q3 The nursing staff began education on the use of the new form on 1/26/11. The form will be used for all residents being transferred for dialysis. Q4 The ADON and Audit Nurse will review the transfer form on dialysis days for compliance and report to the DON. Incomplete transfer forms will be followed up on the same day. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator. **SEE ATTACHMENT #3**	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility Policy and Procedure review, observation and interview, the facility failed to prevent pressure sore development for two residents (#1, #3) resulting in harm to the residents, and failed to accurately assess and provide pressure sore treatment in a timely manner for one resident (#16) of twenty-six residents reviewed. The findings included: Resident #1 was admitted to the facility on November 11, 2011, and readmitted to the facility on November 16, 2011, after a five day hospital stay with diagnoses including Fractured Femur, Acute renal Failure, and Dementia with Behaviors. Medical record review of the Minimum Data Set (MDS) dated November 29, 2011, revealed the resident required extensive assistance for bed mobility and limited assistance for transfers. Medical record review of a Braden Risk scale (Predicts Pressure Sore Risk) dated November 11, 2011, revealed the resident was high risk for pressure sore development. Further medical record review revealed no documention a Braden Scale assessment had been completed for the readmission to the facility on November 16, 2011. Medical record review of the Nurse's Note dated November 16, 2011, revealed "...skin intact..." Medical record review of a Specialized Services dated November 16, 2011, revealed the resident	F 314	**Resident #1** was placed on an alternating pressure air mattress admission November 11, 2011 and readmission on November 16, 2011. Heel protectors were put in place on the first day of both the admission and readmission. A head to toe skin inspection was performed by admitting nurse upon both admissions. Weekly head to toe skin assessments have been completed weekly by the licensed charge nurses assigned to the resident since admissions. A Braden scale and f ull assessment was completed on 1/13/12. On 1/13/12 resident was educated about wearing heel protectors while in bed. This wound was resolved as healed on January 12, 2012. The nursing staff continues to monitor the right heel daily. A heel protector is still being worn on the right heel while in bed. The resident remains on an alternating pressure air mattress. The resident's physician and family have been involved since admission.	2/16/12

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F 314	Continued From page 26 was non-weight bearing for the left lower extremity. Medical record review of a Nurse's Note dated November 25, 2011, revealed "...3 cm (centimeter) x (by) 3 cm darkened area on residents R (right) heel..." Medical record review of a Physician's Order Sheet dated November 25, 2011, revealed "...Apply skin prep to R heel daily until healed..." Medical record review of a Nurse's Note dated December 2, 2011, revealed "...order obtained for heel protectors and off loading (floating) of heels while in bed..." Medical record review of the Physician's Order Sheet dated December 2, 2011, revealed "...Heel protectors to be worn at all times (right heel)...off loading of heels while in bed, heel protector to be worn on left heel except for transfers and ambulating..." Medical record review of the Care Plan dated December 4, 2011, revealed "...at risk for skin breakdown...on admission evaluate skin risk with Braden Scale...perform full body skin assessment...inspect skin daily...consult Registered Dietician as needed..." Medical record review of the Nutrition Note dated December 6, 2011, revealed "...res (resident) wt (weight) down to 120# (pounds) from 127...pt (patient) with wound (unstageable) will initiate... (nutritional supplement) and stress tab (tablet) wt weekly..."	F 314		

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F 314	Continued From page 27 Medical record review of a Physician's Order Sheet dated December 6, 2011, revealed "...Stress Tab daily...Ensure 80 ml (milliliters) four times a day...second to wound... weight loss...needs with wound healing..." Medical record review of the Medication Record dated December 2011, revealed the first dose of the Stress Tab and Ensure was initialed as administered on December 7, 2011. Medical record review revealed the following Skin Assessment Forms: December 4, 2011, "...R heel 3 X 3..." December 23, 2011, "...R heel hard black tx (treatment) continue..." December 30, 2011, "...R heel 7.5 X 3 cm..." January 7, 2012, "...R heel 2.25 X 2.75..." January 12, 2012, "...R heel 2.15 X 2.5..." Review of a facility (untitled) policy and procedure , effective date August 2, 2001, revealed "...patient who enters the facility without pressure sores does not develop pressure sores...skin assessment made according to wound protocol...Braden Risk scale will be performed on admission..." Review of the facility's policy (undated) Skin and Wound Protocol revealed "...notify physician of wound status changes...obtain physician order for treatment..." Observation on January 9, 2012, at 2:15 p.m., on the B-Wing revealed the resident sitting in a wheel chair with no heel protectors in place.	F 314		

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F 314	Continued From page 28 Observation on January 9, 2012, at 3:00 p.m., in the resident's room, revealed the resident lying on the bed and heel protectors were not in place and the heels were not floated. Observation on January 10, 2012, at 8:00 a.m., on B-Wing hallway, revealed the resident sitting in the wheel chair and no heel protectors in place. Observation on January 10, 2012, at 3:30 p.m., in the resident's room, revealed the resident lying on the bed without heel protectors in place and the heels not floated. Interview on January 11, 2012, at 8:30 a.m., with the Director of Nursing (DON), in the B-Wing Nurse's Station confirmed the resident was moderately impaired for decision making, and confirmed the Braden Scale was not completed upon readmission (November 16, 2011); the right heel pressure sore was not identified until November 25, 2011, and a physician's order was not obtained until December 2, 2011, for heel protectors on at all times to the right heel. The DON confirmed the facility policy did not specify the frequency for skin assessments and confirmed weekly skin assessments had not been consistently completed. Further interview with the DON confirmed the pressure sore was identified on November 25, 2011, and the Registered Dietician did not assess the resident's nutritional status for pressure sore healing until December 6, 2011, when an order was obtained for nutritional interventions to promote wound healing. The DON confirmed the pressure sore was avoidable and the physician's orders for heel protectors and floating of the heels had not been consistently implemented.	F 314		

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F 314	Continued From page 29 Resident #3 was admitted to the facility on October 14, 2011, with diagnoses including Diabetes Mellitus, Dementia, Benign Prostate Hypertrophy, Muscle Weakness. Medical record review of the admission Minimum Data Set (MDS) dated October 26, 2011, revealed the resident had severe cognitive impairment. Medical record review of a Braden Scale completed October 14, 2011, revealed the resident was high risk of developing a pressure sore. Review of the facility provided documentation (progress note) dated November 16, 2011, revealed "...abrasion right heel/blue/purple...1.5 X (by) 1 cm (centimeter)...reddened area around the abrasion, area closed, had tennis shoes on with no socks...could have potentially caused abrasion..." Medical record review of a Physician's Order Sheet dated December 5, 2011, revealed "...skin prep (preparation) daily until healed...2.5 cm X 2.3 cm darkened area on R (right) heel..." Review of the facility policy (undated) Skin and Wound Protocol revealed "...notify physician of wound status...obtain order for treatment..." Observation on January 9, 2012, at 9:40 a.m., revealed the resident was seated in a wheel chair and propelled self by sliding the feet in a back/forward motion on the floor to move self up and down the hallway outside of the resident's	F 314	**Resident #3** was placed on alternating pressure air mattress on admission. A complete full skin assessment (head to toe skin inspection) was completed on admission by admitting licensed nurse. Charge nurses are continuing to treat the right heel which began as an abrasion. Weekly full skin assessments have been completed each week since January 12, 2012 with no new skin problems noted. The right heel wound is steadily improving. CNA's and nurses are monitoring the resident to ensure that he is wearing socks and encouraging him to leave the socks on while wearing shoes. (The resident and his wife prefer not to wear socks. The resident's wife has been counseled about the need for her husband to wear socks.)	

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F 314	Continued From page 30 room. Interview and documentation review of a Nutritional Note dated December 27, 2011, with the ADON and the Registered Dietician (RD) on January 10, 2012, at 9:00 a.m. in the facility billing office confirmed there was no documentationthe RD was notified of the pressure sore (discovered on November 16, 2011) until December 27, 2011, at which time a Stress Tablet and a prealbumin level was recommended. Continued interview and review of the prealbumin level (ordered by the physician on December 29, 2011) results obtained on December 30, 2011, revealed the prealbumin results were 14.6 (low) (range Low =18.0, High = 38). Observation with Charge Nurse #1 and the Assistant Director of Nursing (ADON) on January 10, 2012, at 11:12 a.m. in the resident's room revealed the resident had two dark areas on the right heel measuring 1 cm X .8 cm and .2 cm X .3 cm. Interview with the ADON on January 12, 2012, at 8:50 a.m., in thr Director's office confirmed the resident developed an avoidable pressure sore on the right heel; confirmed the facility failed to ensure socks were worn with shoes, and the resident used the feet to propel self in a wheel chair by sliding the feet on the floor. Continued interview confirmed the RD was not notified of the pressure sore until December 27, 2011. Resident #16 was readmitted to the facility on February 23, 2011, with diagnoses including Stage Four Renal Insufficiency, Cellulitis, Falls	F 314	**Resident #16** was admitted with multiple stasis ulcers to the lower legs and feet. He was placed on an alternating pressure air mattress upon admission. The charge nurse responsible for the wound assessment on 1/11/12 was educated and counseled in regard to not including new ulcers on toes on the assessment and not obtaining new orders from the physician for a new wound on the buttocks and toes. Q2 All current residents and new admissions to the facility have the potential to be affected by this deficient practice. Braden scale and full skin assessments are performed on each admission to the facility and will now also be performed on readmissions. An audit of all new admissions since the state survey revealed that the Braden scale and full skin assessments (head to toe skin inspection) were completed on these residents. Weekly full skin assessments (head to toe skin inspection) are performed on all residents by licensed nurses assigned. Braden scale and full skin assessments are completed quarterly with each MDS assessment.	

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F 314	Continued From page 31 and Dementia. Medical record review of the Minimum Data Set (MDS) dated October 31, 2011, revealed the resident was at risk for developing pressure ulcers; always incontinent of bladder and bowel, and required total dependence cleansing self after elimination. Observation with the Assistant Director of Nursing (ADON), on January 11, 2012, at 3:20 p.m., in the resident's room revealed the resident had a sore to the left Great toe with a black area to the inner aspect of the sore and the second toe had a red area, draining clear fluid, to the inner aspect of the toe. Interview with the ADON on January 11, 2012, at 3:30 p.m., in the resident's room confirmed the resident had developed sores and the ADON stated the Licensed Practical Nurse would complete a wound assessment and notify the physician for orders. Medical record review of a Nurse's Note dated January 11, 2012, at 4:00 p.m., revealed "...checked all of residents wounds...left lower buttocks 1cm x .5 cm... " and no documentation of an assessment of the toes. Medical record review of the Skin Assessment Form dated January 11, 2012, revealed "Lt. (left) buttocks 1 cm X .5 cm area..." and no documentation of an assessment of the sores on the left foot. Medical record review completed on January 12, 2012, at 8:20 a.m., of the January 2012,	F 314	Q3 All nursing home staff where in-serviced on the revisions that were made to the policy and protocol for wound care on 2/1/12 and 2/8/12. All staff was also reeducated on prevention which included: heel protectors, socks with shoes, pillows, mattresses, cushions and documentation of these protective items in the residents' medical record. Staff unable to attend and PRN staff will be notified for makeup education prior to returning to work. At future monthly Staff Meeting a portion of each meeting will be allocated to review wound care protocol and education on Skin Care Management. The facility has ordered professionally made Power Point wound care education program on 1/27/2012 which will be mandatory for all licensed nurses. The facility will extend the Q-Source engagement to include wound care assistance. At least three staff members including a licensed nurse, a therapy representative and one other staff member will attend a Pressure Ulcer Staging and Documentation course taught by a Certified Wound Specialist, in Nashville on 3/9/2012.	

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F 314	Continued From page 32 Treatment Record revealed no new orders/treatments for the sores on the resident's buttocks/toes identified on January 11, 2012. Observation with the Director of Nursing (DON) and the ADON, on January 12, 2012, at 8:45 a.m., in the shower room, revealed the resident had a stage two pressure sore to left buttocks measuring 1cm x .5 cm. Medical record review of a Physician's Order Sheet dated January 12, 2012, at 1:00 p.m., revealed "...pt (patient) with new sores reported...great toe and buttocks...will continue to have breakdown periodically second to chronic medical problems..." Review of an undated facility policy titled Skin and Wound Protocol revealed "...notify physician of wound status changes...obtain physician order for treatment..." Interview with the DON on January 12, 2012, at 8:50 a.m., at the B-Wing Nurse's Station, confirmed the resident had new areas of skin breakdown observed on January 11, 2012 and the skin assessment form completed January 11, 2012, did not include an assessment of the sores on the left toes. Further interview with the DON confirmed the physician was notified of the sores on January 11, 2012 and a treatment order was not obtained until January 12, 2012.	F 314	Q4 Event Reports on any new skin findings are completed and submitted to DON. Events are reported to NH Administrator each morning M-F at stand up meetings and forwarded to Medical Director for review. DON and ADON monitoring for compliance for notification to physician and family. DON, ADON and Audit Nurse monitoring for compliance for weekly head to toe skin inspections. The Registered Dietitian will monitor referrals made secondary to a low Braden scale and new wounds. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator. **SEE ATTACHMENT #4**	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		

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F 315	Continued From page 33 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement an individualized bladder training program for one resident (#6) of twenty-six residents reviewed. The findings included: Resident #6 was readmitted to the facility after a hospital stay on October 25, 2011, with diagnoses including Septic Arthritis, Osteomyelitis, Diabetes Mellitus, and Incontinence. Medical record review of the Nursing Home Resident Care Record dated October 1, 2011, through October 14, 2011, revealed prior to hospital stay the resident was continent of urine daily. Medical record review of the Nursing Home Resident Care Record dated October 25, 2011, through October 31, 2011, (after return from hospital) revealed the resident was incontinent of urine daily. Interview on January 11, 2012, at 9:00 a.m., with the Director of Nursing, at B-Wing Nurse's Station, confirmed a bladder assessment had	F 315	A bladder assessment was done on **Resident #6** on 1/13/12. She scored "as not a candidate" for bladder retraining due to decreased memory skills. On 1/13/12 the Resident was placed on a scheduled toileting plan which is currently in place Q2 All incontinent residents currently in the facility have the potential to be affected by this deficient practice. All residents on admission, readmission and/or significant changes will be assessed and reassessed for bladder retraining Q3 The MDS coordinators, clinical staff and interdisciplinary team were reeducated on 2/1/12 and 2/8/12 during the mandatory staff meeting regarding the importance of bladder retraining assessments and bladder retraining. Staff unable to attend and PRN staff will be notified for makeup education prior to returning to work. Q4 The DON, ADON, chart audit nurses and interdisciplinary team will monitor for compliance. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	2/6/12

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F 315	Continued From page 34 been completed after the resident had returned from the hospital stay and confirmed a bladder training program had not been implemented to restore/improve bladder continence.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one resident (#10) and failed to implement a intervention for one resident (#16) after a non-injury fall. The findings included: Resident #10 was admitted to the facility on May 18, 2011, with diagnoses including Dementia with Behaviors and Falls. Medical record review of the Minimum Data Set (MDS) dated October 22, 2011, revealed the resident required extensive assistance for transfers, and had not experienced a fall since the last assessment. Medical record review of a Screen for Fall Risk dated May 18, 2011, revealed resident was high	F 323	**Resident #10** was admitted on 5/18/11 with a history of falls. A clip alarm in the wheelchair was implemented for his safety. He had a fall on 6/11/11 from the wheelchair where the clip alarm had detached from a shirt and therefore did not activate. There was no injury. A pressure pad alarm was implemented. Because of frequent movement the pad alarm activated even though the resident was not attempting to get up. The "new" chair (Rock N Go) was ordered and received for this resident, the interdisciplinary falls team made a decision to try the clip alarm again which currently has been in place and been successful since 8/1/11. The physician order and care plan reflected "clip alarm" in a " Rock N Go" chair. **Resident #16** had a fall from a wheelchair on 1/10/12. His wheelchair was immediately tilted back because he had slid to the edge of the seat and out to the foot rests. On 1/11/12 a pommel cushion was placed in the wheelchair.	2/16/12

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F 323	Continued From page 35 risk for falls. Medical record review of a Nurse's Note dated June 11, 2011, revealed "...in floor in front of W/C (wheelchair)... " Medical record review of a facility investigation report dated June 11, 2011, at 8:55 p.m., revealed "...lying in floor...clip alarm pulled off shirt...not activated... " Medical record review of a Progress Note Listing dated June 11, 2011, at 8:55 p.m., revealed "...clip alarm had detached...not activating the alarm...intervention...pressure pad alarm placed on W/C... " Medical record review of the Interdisciplinary Care Plan dated May 31, 2011, and last reviewed October 24, 2011, revealed "...at risk for falls...clip alarm in wheel chair... " Observation on January 9, 2012, revealed the resident in the wheel chair with a clip alarm in place and no pressure pad alarm on the wheel chair. Interview on January 10, 2012, at 9:10 a.m., with the Director of Nursing (DON) at the A-Wing Nurse's Station confirmed the pressure pad alarm was not on the wheel chair. Resident #16 was readmitted to the facility on February 23, 2011, with diagnoses including Stage Four Renal Insufficiency, Falls, and Dementia. Medical record review of the Minimum Data Set	F 323	Q2 All residents currently in the facility and especially those at high risk to fall could potentially be affected by this deficient practice. All residents are assessed for fall risk on admission, quarterly, with significant changes and after a fall. Q3 The interdisciplinary team meets weekly to discuss all falls, alarms, restraints, and staff concerns over positioning devices. Positioning devices and residents with risks for fall are discussed weekly for residents whose care plans are being reviewed. Falls and fall risks are discussed during the facility daily stand-up meetings. Staff was reeducated on 2/1/12 and 2/8/12 during the mandatory staff meeting regarding the use of alarms, restraints, and positioning devices. Staff unable to attend and PRN staff will be notified for makeup education prior to returning to work. Q4 DON, ADON and Therapy Manger to monitor compliance of alarm devices and positioning devices. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 323	Continued From page 36 (MDS) dated October 31, 2011, revealed the resident was totally dependent for transfers, did not ambulate, and had not experienced a fall since the last assessment. Medical record review of a Nurse's Note dated January 10, 2012, revealed "...resident to ER (emergency room) fell out of chair... " Medical record review of a facility investigation report dated January 10, 2012, at 10:20 a.m., revealed "...witnessed fall... " Medical record review of the Interdisciplinary Care Plan revealed no updates since resident fell on January 10, 2012. Interview on January 11, 2012, at 4:25 p.m., with the DON at the B-Wing Nurse's Station confirmed no new intervention to prevent further falls from the wheel chair had been implemented since the fall from the wheel chair on January 10, 2012.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	Continued From page 37 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to prevent the administration of an unneccessary drug for one resident (#6) of twenty-six residents reviewed. The findings included: Resident #6 was admitted to the facility on July 11, 2005 with diagnoses including Diabetes, Hypertension, and Dysphagia. Medical record review of a pharmacy consultation report dated November 1, 2011, and signed by the physician on November 10, 2011, revealed "takes Tolterodine (Detrol)...4 mg (milligrams) daily...Recommendation: Please consider reducing Tolterodine to 2 mg daily...Physician's Response: I accept the recommendation(s) above, please implement as written..." Medical record review of the Medication Record dated November 1, 2011, through November 30, 2011, revealed Detrol LA 4 mg initialed as	F 329	**Resident #6** did not experience any adverse signs or symptoms during the nine day time frame. Resident #6 had the dosage of Detrol from 4 mg to 2 mg daily on 11/16/11. The physician was notified by the DON on 1/27/12 of the unnecessary doses of Detrol. Q2 All current residents in the facility could be potentially affected by this deficient practice. Q3 All consultations and recommendations are being hand carried by courier daily M-F to and from physician offices for acceptance or rejection. These will be handled on the same day when at all possible or as soon as possible otherwise. Q4 The DON, ADON, and chart audit nurse will monitor the compliance weekly for eight weeks and then monthly. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	2/10/12

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F 329	Continued From page 38 administered on November 10, 2011, through November 16, 2011. Interview on January 11, 2012, at 9:00 a.m., with the Director of Nursing (DON), in the DON's office confirmed the resident received 4 mg dosage instead of 2 mg dosage November 11-16, 2011, and confirmed an unnecessary higher dosage of the medication was administered.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain proper sanitation for food preparation equipment, safe food temperatures, and safe storage of refrigerated and dry foods in the dietary department. The findings included: Observation and interview on January 9, 2012, at 9:20 a.m., with the Dietary Manager in the dietary department, revealed Dietary Aide #1 wore no hair net; a five gallon clear plastic container labeled gravy bowls was placed on the unclean	F 371	1. Male not wearing a hairnet • All staff will wear a hairnet while in the dietary department at all times. 2. Five gallon bucket with gravy bowls label on the floor. • Removed Immediately. • Under no circumstance will clean buckets or any containers holding clean items be left on the floor for any reason. 3. Water on floor in walk in cooler. Black substance covered three fourths of the kick plate. • Water will be cleaned up daily or as needed. Threshold in walk in cooler has space between threshold and floor, Maintenance notified immediately via. Maintenance requisition. Threshold has been repaired and working properly. All staff will monitor for water and cleanliness.	2/16/12

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F 371	Continued From page 39 floor surface. Observation of the walk-in cooler entrance revealed water was present on the floor and a black substance covered three-fourths of the kick plate. Observation in the cooler revealed a quarter pan (per Dietary Manager) contained a five pound bag of carrots one-fourth full with no date when opened, six ounce bag of radishes in a plastic bag not sealed with no date when opened, five pound bag of coleslaw one-fourth full with expiration date 1-1-12, on a shelf three pieces of French toast with no date when opened, five pound container of pimento spread with an the expiration date 1-3-12. Observation on a storage self revealed a five pound container of tuna salad with an expiration date 12-18-11, one gallon of ranch dressing one-fourth full with an expiration date 7-29-11, and two brown cardboard boxes containing six cartons of frozen eggs stored in a full pan which contained a yellow and brown liquid in bottom of pan. Interview with the Dietary Manager at the time of the observations confirmed all employees are required to wear hair nets; items are not to be stored on the floor, the cooler floor was dirty, and undated/outdated food items were available for resident use. Observation on January 9, 2012, at 9:40 a.m., with the Dietary Manager in the dietary department, revealed twelve hoagie buns with visible mold on the buns stored on a bread rack shelf; a quarter pan on a shelf next to bread rack contained the following items: one 3 ounce package (1/2 full) of ranch dry mix; one fourteen ounce plastic bag (1/2 full) of organic quinoa (rice) 5 ounce package (1/4 full) with no expiration date or date opened. Interview at this time with the Dietary Manager confirmed the items were available for resident use and were	F 371	4. 5lb bag of sliced carrots, no date opened or expiration, 5lb bag of coleslaw no pen or expiration date, radish not sealed, open date or expiration date, French toast with no expiration date, Ranch dressing with no expiration date. • All were thrown out immediately, staff will date all open items with open date and expiration date, All open items will be put in a sealed container. 5. Pimento Cheese Expired. Tuna salad expired. • Thrown out immediately. All staff will check items for expiration date. 6. Hoagie buns on top of Bread rack molded. • Thrown out immediately. All staff will put a expiration date on bread when opened and discarded the day of expiration. 7. Two cases Eggs thawing in walk in had a liquid substance in the bottom of pan. • Eggs will be placed in a clean pan every morning, to keep the frozen condensation out of pan. 8. Dry ranch salad dressing mix was half full and in a Ziploc bag with no open date on package. Rice was also in bag with no open or exp, date. • Packages were thrown out immediately; all items that are opened will be put in a sealed container with open date and discard date. 9. Freezer door not shutting properly. • Freezer door will be cleaned daily to keep ice chipped away so the door will close properly. New gaskets have been ordered for the freezer door.	

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F 371	Continued From page 40 not stored properly. Observation on January 9, 2012, at 9:50 a.m., with the Dietary Manager in the walk in freezer, revealed the temperature was nine degrees below zero and the door to the walk-in freezer did not close properly; ice build-up was on the floor of the freezer; six chicken patties stored in an opened/undated plastic bag; five pound bag of green peas stored in an opened/undated plastic bag; two pounds of diced potatoes in an opened/undated brown bag and a two pound bag of frozen french fries stored in an opened/undated brown bag. Interview at this time confirmed the items were available for resident use and were not stored properly. Observation on January 9, 2012, at 10:15 a.m., with the Dietary manager in the dry storage pantry, revealed twenty-nine .85 ounce packets of Juven (dietary supplement) with the expiration date 1-1-12. Interview at this time confirmed the items were outdated and were available for resident use. Observation on January 9, 2012, at 10:20 a.m., with the Dietary Manager in the dietary department, revealed two dry storage bins labeled flour and sugar with two full pans of uncovered cookies stored on top of the storage bins which was located two inches from a twenty-five gallon gray trash can with the lid three-fourths opened. Interview at this time confirmed the items were not stored in a sanitary manner. Observation on January 10, 2012, at 11:20 a.m., with the Dietary Manager in the dietary	F 371	10. Freezer: Chicken patties opened/ undated package, Green peas opened/ undated, diced potatoes opened/undated French fries opened/undated. • Thrown out immediately, staff educated on labeling and dating. 11. Dry storage, Juven expired. • Thrown out immediately, will do morning round to check for expired items. 12. Sugar and flour bins, under counter next to trash can. • Trash can has been moved. 13. Black debris on the rack and sides of the toaster. o Toaster was cleaned immediately. o Kitchen compliance monitoring tool will be used by each shift team leader in the am and pm. 14. Cole slaw temperature was 48. • Staff will pre prepare all refrigeration items the day before needed for tray line to ensure proper temp. • Initiating PI on cold temp foods. • Hot and cold temperatures are taken on the tray line during every meal by the Team Leader and recorded. 15. Employee left the kitchen while wearing gloves. • Employee was stopped and in serviced immediately on proper use of gloves and hand hygiene. All staff was educated on hand hygiene and proper use of gloves. • Hand Hygiene/Glove use Observation Tool will be done at a minimum of twenty times per month.	

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F 371	Continued From page 41 department, revealed black debris on the rack and sides of the toaster and Dietary Aide #2 turned the toaster on for use. Interview at this time confirmed the toaster was unclean. Observation of food temperatures on January 10, 2012, at 11:30 a.m., with the Dietary Manager, in the dietary department, revealed the temperature of the coleslaw was forty seven degrees. Interview at this time confirmed the safe temperature required is forty-one degrees, and confirmed six trays containing one serving each of coleslaw had been served for resident consumption prior to the observation of the unsafe food temperature of forty-seven degrees. Observation with the Dietary Manager on January 10, 2012, at 12:00 p.m., in a hallway outside the dietary department, revealed Dietary Aide #2 exited the dietary department wearing gloves then re-entered the dietry department immediately wearing the gloves and did not remove the gloves or wash the hands and prior to preparing food. Interview at this time with the Dietary Manager confirmed the Dietary Aid failed to remove the gloves and wash the hands upon re-entry into the dietary department and prepared food wearing the gloves.	F 371	**Question #3** • An in-service was given on 1-10-2012, & 1-12-2012. • Kitchen compliance monitoring tool will be used by each shift team leader in the AM and PM. • Food Safety and Sanitation Checklist will be performed at a minimum of two times per week. • Hand Hygiene/Glove use Observation Tool will be done at a minimum of twenty times per month. **Question #4** The results of the Monitoring Tools will be reported to the PI/QA Committee on a quarterly basis by the Registered Dietician. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator. Anything requiring immediate attention will be reported to the Nursing Home Administrator. **SEE ATTACHMENT #5**	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to notify the physician timely of pharmacy consultant reports for four residents (#17, #1, #6, #10) of twenty-six residents reviewed. The findings included: Resident #17 was admitted to the facility on June 9, 2010, with diagnoses including Hypertension, Depressive Disorder, and Malignant Neoplasm of the Skin and Trunk. Medical record review of a pharmacy consultation report dated March 2, 2011, revealed, " ...please consider monitoring a valproic acid serum concentration..." Continued review of the consultation report revealed the physician was not notified of the consultant pharmacist recommendation until March 17, 2011 (a fifteen day delay). Interview with the Assistant Director of Nursing (ADON) on January 12, 2012, at 8:50 a.m., in the Director's office confirmed that the facility failed to notify the physician of the pharmacy consultant recommendations in a timely manner. Resident #1 was readmitted to the facility on November 16, 2011, with diagnoses including Dementia with Behaviors, Acute Renal Failure	F 428	**Resident #17** continues to be seizure free over the past year and has no known harm. Resident #17 was tested for valproic acid serum concentration on 3/17/11. The results of the test proved that the residence valproic acid serum concentration was below normal therapeutic limits and no therapeutic intervention was ordered by the physician. Another valproic acid serum concentration was performed in 9/11. The result was in normal therapeutic limits and there was no therapeutic intervention ordered by the physician. The physician was notified by the DON on 1/27/12. **Resident #1** began receiving calcium 600 mg with vitamin D 400 units on 12/5/11. The resident's medical condition continued to improve during the months of December and January. The physician was notified by the DON on 1/27/12. **Resident #6** did not experience any adverse signs or symptoms during the nine day time frame. Resident received 4 mg of Detrol instead of 2 mg of Detrol. The physician was notified by the DON on 1/27/12. **Resident #10's** did not experience any adverse signs and symptoms from Namenda not being increased. The physician was notified by the DON on 1/27/12.	2/16/12

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F 428	Continued From page 43 and Fractured Femur. Medical record review of a Pharmacist Consultation Report dated December 7, 2011, revealed "...consider initiating Calcium 600 mg (milligram) with vitamin D 400 Units twice daily..." Continued medical record review revealed the recommendation was accepted by the physician December 16, 2011, (nine days later). Interview on January 10, 2012, at 8:30 a.m., with the ADON, at the B-Wing Nurse's Station, confirmed the facility failed to notify the physician of the pharmacist recommendations for the Calcium 600 mg with Vitamin D 400 units in a timely manner. Resident #6 was readmitted on October 25, 2011, with diagnoses including Septic Arthritis, Osteomyelitis, Diabetes Mellitus, and Incontinence. Medical record review of a Pharmacist Consultation Report dated November 1, 2011, revealed "...consider reducing...Detrol (overactive bladder) 4 mg to 2 mg daily..." Continued medical record review revealed the recommendation was accepted by the physician November 10, 2011 (nine days later). Interview on January 11, 2012, at 9:00 a.m., with the Director of Nursing (DON) at the B-Wing Nurse's Station, confirmed the facility failed to notify the physician of the pharmacist recommendations for dose reduction for the Detrol in a timely manner. Resident #10 was admitted to the facility on May	F 428	Q2 Residents currently in the facility have the potential to be affected by this deficient practice. Q3 All consultations and recommendations that require physician acceptance or rejection will be hand carried daily M-F to and from the physician's office by courier. All accepted orders will be handled the same day when possible or as soon as possible. A licensed nurses were in service/educated on 2/1/12 or 2/8/12 by the DON regarding the importance of obtaining recommendations from the physician and implementing them as soon as possible. Nurses unable to attend in-service will be identified and educated upon return to work. Q4 The DON, ADON and audit nurses will monitor for compliance weekly for eight weeks and then monthly. The consultant pharmacist will audit monthly during the routine visit. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 428	Continued From page 44 18, 2011, with diagnoses including Dementia with Behaviors and Falls. Medical record review of a Pharmacist Consultation Report dated June 13, 2011, revealed "...consider increasing Namenda (Anti-Alzheimer) to 10 mg each am and 5 mg each pm for one week, then twice daily..." Continued medical record review revealed the recommendation was accepted by the physician June 27, 2011 (two weeks later). Interview on January 9, 2012, at 2:00 p.m., with the DON, in the DON office, confirmed the facility failed to notify the physician of the pharmacist recommendations for increasing the dose of the Namenda in a timely manner.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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F 431	Continued From page 45 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe and secure storage of controlled substances in one of two medication storage areas. The findings included: Observation and interview with Charge Nurse #3 in the A wing medication room on January 11, 2012, at 8:45 a.m., revealed no refrigerator in the medication room. Continued interview at this time revealed the drug refrigerator is kept just outside the medication room not behind a locked door. Observation revealed a small refrigerator with a lock located just outside the medication room containing ten morphine 2 mg (milligram) per one ml (milliliter) carpuject syringes, ten Lorazepam 2 mg per one ml carpujects and one 2 mg per one milliliter vial of Lorazepam.	F 431	The drug refrigerator was immediately moved to a locked room on 1/11/12 at 8:50 AM. Medication in the refrigerator was counted and verified with the state surveyor and compared to the narcotics log. All medications were accounted for. Q2 The drug refrigerator remained in the locked room until a locked drug box was obtained from the consulting pharmacy on 1/19/12. Q3 The locked refrigerator with the internal locked drug box was returned to the nurses' station. All nursing staff participated in an in-service by DON on the regulations related to double locking of controlled substances on 2/1/12 or 2/8/12. Those unable to attend the meeting will be reeducated on a one to one basis prior to their return to work. Q4 The Licensed Consulting Pharmacist will continue to make monthly audits of controlled substances to insure no drugs are missing. DON will make spot checks of refrigerator to make sure that they are locked. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	2/16/12

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F 431	Continued From page 46 Interview with the Director of Nursing in the Director's office on January 11, 2012, at 9:06 a.m., confirmed the facility failed to provide safe and secure storage of controlled medications on the A wing.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**Resident #7** did not develop any symptoms of an infection. Resident #7 was monitored from January 9, 2012 until January 31, 2012 to determine if the resident developed any symptoms of an infection that might have been caused by not bagging the nebulizer mask. **Resident #**8 was monitored from January 9, 2012 until January 31, 2012 to determine if the resident developed any symptoms of an infection that might have been caused by not bagging the nebulizer mask. Resident #8 did not develop any symptoms of an infection. **Charge Nurse #1** when concern was expressed about the glucose strip with visible blood being placed on the over bed table, did clean and disinfect the over bed table in the residents' room. **Resident #10** CNA immediately stripped and remade the bed. Resident was monitored from 1/9/12 until 1/31/12 to determine if the resident developed any symptoms of infection that might be caused by the placement of the falls mat on the resident's bed. There was no known harm. (Continued on page 48)	2/16/12

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F 441	Continued From page 47 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure infection control practices were maintained for five (#7, #8, #3, #10, #16) residents of twenty-six residents reviewed. The finding included: Resident #7 was readmitted to the facility on September 1, 2011, with diagnoses including Muscle Weakness, Paranoid Schizophrenia, Chronic Obstructive Pulmonary Disease, and Hypertension. Observation with Charge Nurse #4 on January 9, 2012, at 9:20 a.m., revealed the resident lying on the bed. Continued observation revealed a nebulizer mask (aerosol treatment) lying on the bedside table uncovered. Interview with Charge Nurse #4 on January 9, 2012, at 9:20 a.m., in the resident's room, confirmed the nebulizer mask was to be placed in a bag when not in use. Resident #8 was admitted to the facility on September 30, 2005, with diagnoses including Depression, Diabetes, Dementia, and Esophageal Reflux.	F 441	**Resident #16** CNA immediately stripped and remade the bed. Resident was monitored from 1/11/12 until 1/31/12 to determine if the resident developed any symptoms of infection that might be caused by the placement of the linen bag on the resident's bed. There was no known harm. Q2 All current residents in the facility could potentially be affected by this deficient practice. All nebulizer bags were checked 1/9/12 by DON to ensure that they were stored in the appropriate bags. Charge Nurse #4 and #5 were reeducated by the director of nursing on 1/9/12 that all nebulizer masks when not in use should be placed in a bag. Charge Nurse #1 was counseled by the DON on January 10, 2012 concerning the nursing home policy related to infection control and the handling of glucose strips All CNA's on duty on 1/9/12 were reminded by the ADON not to place items including falls mats on residents' beds. All beds were checked on 1/9/2012 for inappropriate items on beds. (Continued on page 49)	

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F 441	Continued From page 48 Observation with Charge Nurse #5 on January 9, 2012, at 9:45 a.m., in the resident's room revealed the resident seated in a wheelchair. Continued observation revealed a nebulizer mask lying on the bedside table uncovered. Interview with Charge Nurse #5 on January 9, 2012, at 9:45 a.m., in the resident's room, confirmed the nebulizer mask was to be placed in a bag when not in use. Resident #3 was admitted to the facility on October 14, 2011, with diagnoses including Dementia, Benign Prostate Hypertrophy, Muscle Weakness, and Diabetes Mellitus. Observation in the resident's room on January 10, 2012, at 11:31 a.m., revealed Charge Nurse #1 obtained a lancet and stuck the finger of resident #3. Further observation revealed the Charge Nurse placed the finger with visible blood against a blood glucose strip, then placed the strip with visible blood on top of the roommate's overbed table. Interview with Charge Nurse #1 and the Assistant Director of Nursing on January 10, 2012, at 11:32 a.m., outside the resident's room confirmed the contaminated strip was placed on the roommate's overbed table and the table was not cleaned/disinfected until concern was expressed to the Charge Nurse. Resident #10 was admitted to the facility on May 18, 2011, with diagnoses including Dementia with Behaviors and Falls.	F 441	Q3 All staff received in-service training by the DON on 2/1/12 and 2/8/12 to make sure that all nebulizer masks when not in use are to be placed in the bag provided for that purpose. All staff received in-service training on 2/1/12 and 2/8/12 by the DON to review the nursing home policy related to infection control and handling of glucose strips. On 2/1/12 and 2/8/12 at the all staff meeting, all employees were instructed not to place soiled items and items from the floor on residents' beds. Staff unable to attend the meeting will be educated in in-service upon their return to work. Q4 DON, or ADON or Audit Nurse or Infection Control Nurse will monitor for compliance randomly on walking rounds. A report of compliance will be made by the DON at the PI/QA at next scheduled meeting and at least on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	

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F 441	Continued From page 49 Observation on January 9, 2012, at 3:15 a.m., in the resident's room revealed staff preparing to place the resident in the bed. Continued observation revealed the staff picked up a falls mat which was lying on the floor next to the resident's bed. Continued observation revealed Certified Nurse Technician (CNT) #2 placed the falls mat onto the resident's bed, removed the mat and without changing the bed linens placed the resident on the bed. Interview on January 9, 2012, at 3:15 a.m., with CNT #2 outside the resident's room confirmed the unclean fall mat had been placed on the residents bed linens and the linens were not changed prior to assisting the resident into bed. Interview on January 9, 2012, at 4:00 p.m., with the Assistant Director of Nursing (ADON) at B-Wing Nurse's Station confirmed the facility failed to maintain infection control prevention measures. Resident #16 was readmitted to the facility on February 23, 2011, with diagnoses including Stage Four Renal Insufficiency, Falls, and Dementia. Observation on January 11, 2012, at 3:20 p.m., in the resident's room revealed the staff preparing to place the resident in bed. Continued observation revealed two clear plastic bags of soiled linen lying on the floor and Certified Nurse Technician (CNT) #1 picked up the clear plastic bags from the floor and layed the bags on the bed. Interview on January 11, 2012, at 3:20 p.m., with CNT #1 in the resident's room confirmed the	F 441		

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F 441	Continued From page 50 plastic bags contained soiled linen and bags that had been placed on the floor and confirmed the bags were placed on the bed linens. Interview on January 12, 2012, at 8:50 a.m., with the Director of Nursing (DON) at the B-Wing Nurse's Station, confirmed the facility failed to maintain infection control prevention measures.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain labs timely for three residents (#8, #3, #17) of twenty-six residents reviewed. The findings included: Resident #8 was admitted to the facility on September 30, 2005, with diagnoses including Depression, Diabetes, Dementia, and Esophageal Reflux. Medical record review of the physician's recapitulation orders dated December 1, 2011, through December 31, 2011, revealed, "...Hgb AIC (test to monitor blood sugar) every 3 months..." Medical record review revealed the Hgb AIC was obtained on July 6, 2011, and December 30,	F 502	Resident #8 has A1C hemoglobin ordered for every three months. During the internal audit process of the facility in December 2011 it was noted that the A1C hemoglobin was missed for the month of October. On 12/30/11 the physician was notified, HGB A1C was obtained and the results were reported back to the physician. There were no changes in treatment. Resident had suffered no known harm. The date for the next A1C hemoglobin is due on 3/20/12. The Kardex was updated on 12/30/11 to reflect the new date. Resident #3 was tested for prealbumin levels on 12/29/11 The results of the prealbumin test indicated the resident was slightly below the normal range. Stress tab vitamins were ordered and initiated On 12/27/11. On 1/3/12 extra protein was ordered with each meal. The resident's medical condition continues to improve. After performing a root cause analysis it was determined that physician standing orders should be updated to include adding protein to meals when prealbumin levels are below the normal range. The physician and dietitian will be notified when these orders are implemented. (Continued on page 52)	2/16/12

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F 502	Continued From page 51 2011. Interview on January 10, 2012, at 9:10 a.m., in the Director of Nursing office, with the Assistant Director of Nursing, confirmed the Hgb AIC due in October was not completed until December. Resident #3 was admitted to the facility on October 14, 2011, with diagnoses including Dementia, Benign Prostate Hypertrophy, Muscle Weakness, and Diabetes Mellitus. Medical record review of a Physician's Order Sheet dated December 27, 2011, revealed, " ...prealbumin...2 (secondary) wound..." Continued medical record review revealed the prealbumin was not ordered until December 29, 2011, (two day delay). Interview with the Assistant Director of Nursing and Charge Nurse #4 (the nurse responsible for taking the lab order) at the B wing nurse's desk on January 10, 2012, at 9:10 a.m., confirmed the lab was not obtained timely. Resident #17 was admitted to the facility on June 9, 2010, with diagnoses including Hypertension, Depressive Disorder, and Malignant Neoplasm of the Skin and Trunk. Medical record review of a pharmacy consultation report dated March 2, 2011, revealed, "...please consider monitoring a valproic acid serum concentration..." Continued review of the consultation report revealed the physician was not notified until March 17, 2011 (a fifteen day delay).	F 502	Resident #17 was tested for valproic acid serum concentration on 3/17/11. The results of the test proved that the resident's valproic acid serum concentration was below normal therapeutic limits. The physician was notified and no therapeutic intervention was ordered by the physician at this time. Valproic acid serum concentration was performed in September 2011. The result was in normal therapeutic limits and there was no therapeutic intervention ordered by the physician. The resident continues to be seizure free over the past year. Q2 All current residents in the facility could potentially be affected by this deficient practice. From 1/17/2012 - 1/27/2012 100% of all MAR's, TAR's, physician orders and Kardexes were reviewed for accuracy by the DON, ADON audit nurse and staff nurses. Q3 The Kardex for each resident will be reviewed on a weekly basis by the audit nurse. All staff were in-service by DON on 2/1/12 or 2/8/12 about the importance of projecting the next dates for laboratory work on the Kardex and getting the pharmacy recommendations to physicians and back and implemented timely (as soon as possible). Staff unable to attend these meetings will be identified in in-service upon return to work. (Continued on page 53)	

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F 502	Continued From page 52 Interview with the Assistant Director of Nursing on January 12, 2012, at 8:50 a.m., in the Director's office confirmed that the facility failed to ensure the lab was done timely.	F 502	Q4 The DON, ADON and audit nurses will monitor for compliance. The DON will report the results to the PI/QA committee on a quarterly basis. The PI/QA committee membership includes: the Medical Director, DON, ADON, Audit Nurses, Activity Director, Social Worker, Dietitian, Rehab Representative and NH Administrator.	